

ADULT HEALTH AND REGISTRATION FORM

A. PERSONAL INFORMATION *(please print)*

Surname: _____ Given name: _____ Sex: _____

Age: _____ Birth date (Y-M-D): _____ Health card no. (recommended): _____

Home address: _____

City, postal code: _____ Phone: () _____

B. EMERGENCY CONTACT IN CASE OF ILLNESS

Name: _____ Relationship: _____ Phone: () _____

Family doctor's name: _____ Doctor's phone: () _____

C. PERSONAL MEDICAL CONDITIONS AND SPECIAL NEEDS *(attach further information if necessary)*

1. Do you have any allergies?*(check ✓ for 'yes')

Insect Plant Food Drug Other

If you have checked ✓ any of the above, please provide details:

2. Do any of the following medical conditions apply to you? (check ✓ for 'yes')

Diabetes Rash Asthma Epilepsy Heart condition Recent illness/operation
 Contact lenses Other

If you have checked ✓ any of the above, please provide details:

3. Will you be on medication while at the field centre? (If yes, please describe.)

4. Describe any food restrictions that you have (e.g., religious, vegetarian, etc.).

***Note: Participants with anaphylactic conditions must be accompanied with two epipens.**

D. VISITING INFORMATION

Location: Claremont Field Centre

School/group: _____ Date of visit: _____

Signature: _____ Date: _____

The above information is collected under the Conservation Authorities Act. It will be held in confidence during your stay at the field centre and returned after the visit. If you have any questions regarding the collection and use of this information, please contact the field centre supervisor.